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The Pulse of CMS

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Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

CMS Administrator Scully Steps Down

Tom Scully, Administrator of the Centers for Medicare & Medicaid since March, 2001, announced his resignation of the post effective December 16, 2003. During his tenure, Mr. Scully has been credited with creating a "culture of responsiveness" within the agency, first and foremost with the agency's name change in July, 2001, and more definitively with the advent of the Open Door Forum calls. He also spearheaded the quality initiatives that have resulted in the public reporting of quality indicators for nursing homes, home health agencies and hospitals across the country. Perhaps most notably, Scully played a crucial role on Capitol Hill in lobbying for passage of the Medicare Reform legislation.

For more on the Administrator's resignation, visit http://www.cms.hhs.gov/media/press/release.asp?Counter=917

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Quality and Home Health Care

At a press conference held on November 3 in Washington DC, DHHS Secretary Tommy Thompson and CMS Administrator Tom Scully announced the national launch of the Home Health Quality Initiative (HHQI) to provide consumers with access to new, objective quality information about home health agencies all across the country. The Initiative is a national effort by CMS to improve the quality of care given to the millions of Americans and their families using home health care services.

Consumers now have access to quality measures and data that can play a large role in helping them make more informed health care decisions. The 11 quality measures used for home health agencies are based on OASIS measures and are widely known within the industry. These measures address issues such as mobility, activities of daily living, medical emergencies, and mental health.

In addition to the public reporting of quality data, the Initiative provides technical assistance and training to home health agencies in order to improve the quality of the care and services they offer. Medicare's Quality Improvement Organizations (QIOs) in every state have made their resources available—at no cost to home health agencies, nursing homes and hospitals—to improve the overall quality of care for beneficiaries.

Information regarding the quality measures and how each Home Health Agency measures up is available at the Home Health Compare webpage at www.medicare.gov .

Voluntary Hospital Reporting Initiative

As part of its continuing effort to assure quality health care for all Americans through accountability and public disclosure, CMS has collaborated with the American Hospital Association (AHA), the Federation of American Hospitals (FAH), and the Association of American Medical Colleges (AAMC) in the National Voluntary Hospital Reporting Initiative (NVHRI). The purpose of the initiative is to collect and report hospital quality performance information in order to support providers and clinicians in their efforts to improve overall health care quality.

The goal of the initiative is to make critical information about hospital performance accessible to the public, to empower consumers to make informed choices about the care they receive, and stimulate efforts to improve the quality of hospital care. In so doing, the project seeks to construct one robust, prioritized and uniform set of quality measures reported by every hospital and accepted by all purchasers, payers and accrediting bodies.

CMS is currently coordinating its efforts with the Quality Improvement Organizations and Hospital Associations in each state in their educational and outreach efforts. Stay tuned for much more on the NVHRI in the coming months, and visit http://cms.hhs.gov/quality/hospital for periodic updates.

Outpatient Therapy Cap Limits Moratorium

Congress has reinstated the moratorium on limits on reimbursement for outpatient therapy services (therapy caps), effective for claims received on or after December 8, 2003. However, claims for services that were rendered on or after September 1, 2003, which were received prior to December 8, 2003, are subject to the therapy caps. The caps do not apply to services provided by hospital outpatient departments.

Enacted as part of the Balanced Budget Act of 1997, the $1500 cap on outpatient physical therapy and speech therapy, and a separate $1500 cap on occupation therapy went into effect January 1, 1999. The caps were suspended for January 1, 2000 through December 31, 2002, based on provisions in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000. Although the moratorium expired January 1, 2003, the caps were not implemented until September 1. The moratorium was reinstated by Section 624 of the Medicare Prescription Drug and Modernization Act of 2003. These changes have been made in the Medicare Internet Only Manual via Change Request 3005.

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E-mail your questions and comments to us at: Atl_Provider Questions@cms.hhs.gov

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Making Progress Under HIPAA

The October 16 due date to comply with the Transaction and Code Set provisions of the Health Insurance Portability and Accountability Act (HIPAA) has come and gone. Much has been said about contingency plans, enforcement policies, and the continuation of operations; but what does this mean to you, the healthcare provider?

It is important to understand that October 16 was, and still is, the due date for compliance with the Transaction and Code Set provisions of HIPAA. This date has not been changed. CMS has exercised its ability to enforce the flexibility found in 1176 (b) of the law. In doing so, CMS has stated that penalties will not be imposed on covered entities deploying contingency plans after the October 16 compliance date, **as long as a reasonable and diligent effort to gain compliance can be demonstrated**. CMS also announced that Medicare would implement its contingency plan to permit the processing of non-HIPAA compliant transactions so that claims can be processed for the thousands of providers who were not able to meet the deadline and otherwise would have had their Medicare claims rejected.

What this means is that providers will be allowed to submit claims to Medicare via the pre-HIPAA electronic transactions while they continue to work toward gaining HIPAA compliance—remembering that the provider's past actions must indicate due diligence and reasonable efforts in working toward compliance.

The contingency plan is only for a limited time. Providers who continue to bill and receive non-compliant formats should test and move into production on the HIPAA-required formats as soon as possible, or risk possible cash-flow problems.

For additional information on this or any other HIPAA-related issue, please visit the CMS HIPAA Web site at: www.cms.hhs.gov/hipaa/hipaa2

Medicare Prescription Drug & Modernization Act

CMS is looking forward to enactment of the Medicare Prescription Drug and Modernization Act of 2003. In upcoming editions, *The Pulse* will provide regular updates and information on legislation, regional office contacts and available resources for technical information and assistance. Stay tuned!

Studying Health Care Statistics

An often-overlooked resource for health researchers is CMS' Office of the Actuary (OACT). OACT provides actuarial, economic and statistical services to various CMS components, other Federal agencies, the Medicare Board of Trustees, Congress, national advisory commissions, health research groups and outside organizations. The Office is comprised of two areas described below.

The Medicare and Medicaid Cost Estimates Group performs actuarial evaluations, analyses and projections of Medicare and Medicaid program expenditures under current law as well as proposed modifications to these laws. These estimates are used in the president's budget.

National Health Statistics Group deals with the economic aspects of the nation's health care system, including the analysis of National-Health Expenditure Accounts. These accounts track total spending on health care in the U.S. by type of service and source of funding, and projects future national health expenditures. In addition, the NHSG periodically estimates health spending by type of service and funding sources for states and broad population age groups. The group is also responsible for estimating Medicare price indexes used in annually escalating prices Medicare pays to providers for services provided to Medicare beneficiaries.

CMS Launches "Operation Wheeler Dealer"

On September 9, 2003, CMS Administrator Tom Scully, issued a press release announcing a 10-point initiative to curb substantially the abuse of the Medicare program by unscrupulous providers of power wheelchairs and other power mobility products. This press release can be viewed in full at www.cms.hhs.gov/media.

The Administrator singled out Houston (Harris County) as a particularly egregious area. Specific steps designed to help control the rampant fraud and abuse in Houston were included in the national plan. While attention is currently focused on Houston, it is clear that the problem has spread to other areas of Texas, as well as to other states. The CMS Dallas Regional Office staff has pursued the following immediate actions:

- Performing medical review of all motorized wheelchair claims approved by the Region C DMERC prior to issuing a payment. This review includes claims from suppliers and beneficiaries located in Harris County, Texas.
- Training to a group of suppliers in Harris County on October 14-15. Training included medical policy and Medicare coverage guidelines and was mandatory for these suppliers.
- Pursuing action against any physicians that participated in this activity by fraudulently approving unnecessary equipment via the Certificate of Medical Necessity.

CMS, along with its law enforcement partners, is aggressively pursuing civil and criminal prosecutions and other legal remedies to stop this massive fraud scheme. Suppliers may call 1-866-270-4909. Beneficiaries and others may call 1-800-583-2236 to report suspected fraud relating to this activity.

Atlanta RO Exhibits at SMA Scientific Assembly

The Atlanta Regional Office sponsored an exhibit at the Southern Medical Association's 98th Scientific Assembly held in Atlanta, November 6-8, 2003. The exhibit was the first at an SMA event, which included the participation of over 700 physicians. It was one example of the various events the Atlanta RO participates in throughout the region to communicate proactively with providers about Medicare and Medicaid.

Pictured: Rick Jones (CMS) assists a Physician with Medicare information. Assisting are Richard Devon (CMS), Latrelle White (Cahaba GBA), Sonda Bourgeois (BCBS of GA)

One-Stop Shopping for Educational Information

Does your association's membership struggle to obtain accurate information about CMS policies? Has your physician group practice had difficulty educating new billing staff about basic Medicare requirements? Are new physician hires unfamiliar with important Medicare "incident to" provisions? If you answered yes to any of these questions, CMS encourages you to take advantage of Medlearn at www.cms.hhs.gov/medlearn. The Web site is a free information resource for the physician and provider communities. Debuting in January 2000, Medlearn contains numerous educational and training resources in electronic form, and is one element of CMS' ongoing effort to communicate and provide additional explanation of our processes and policies.

Videotapes, CD-ROMs, and written publications are among the varied resources that can be ordered at no cost from the Medlearn Web site. Make Medlearn your first stop for free, accurate information about Medicare.

Visit http://cms.hhs.gov/medlearn/ for more information.

Medicare Learning Network

Medicare Premium & Deductible Rates for '04

The Department of Health and Human Services (DHHS) recently announced the Medicare premium, deductible and coinsurance amounts to be paid by Medicare beneficiaries in 2004.

For Medicare Part A, the deductible paid by the beneficiary increases by $36 to $876 in 2004. The monthly premium paid by beneficiaries enrolled in Medicare Part B will increase $7.90 (or 13.5%) to $66.60 for 2004.

The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care. However, for extended Medicare-covered hospital stays, beneficiaries must pay an additional $219 per day for days 61 through 90 in 2004, and $438 per day for hospital stays beyond the 90th day in a benefit period. For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 will be $109.50 in 2004.

States have programs that pay some or all premiums and coinsurance for certain low-income beneficiaries with Medicare. Information is available at 1-800-MEDICARE (1-800-633-4227) and, for hearing and speech impaired, at TTY/TDD: 1-877-486-2048.

Calendar of Events

November

11/6-8: CMS Exhibit at Southern Medical Association Scientific Assembly, Atlanta

11/18: 2004 Provider Forum planning conference calls with Associations

(Home Health, Hospital, SNF/LTC, Hospice)

December

12/9: 2004 Provider Forum planning confernce call (Physicians)

January

February

2/3-4: Hospital Forum, AFC, Atlanta

2/3: National Hospital Open Door Forum from Atlanta

2/4-5: Home Health Forum, AFC, Atlanta

2/19-20: Physician Forum, AFC, Atlanta

2/24-25: SNF/LTC Forum, AFC, Atlanta

2/25: National Health Plans Open Door Forum from Atlanta

March

3/15-16: Hospice Forum, AFC, Atlanta

Medicare Update...

For timely and relevant information for Medicare providers visit: www.cms.gov/medlearn

To learn how 2004 Medicare+Choice plan withdrawals affect your state visit: http://cms.hhs.gov/healthplans/nonrenewal/

Information Disclaimer:
The information provided in this newsletter is intended only to be general summary information to the Region 4 provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:
Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS or CMS. HHS or CMS is not responsible for the contents of any "off-site" resource identified.

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